Medicare Reimbursement

In 2013

A Risk Management Roadmap for Attorneys

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If you are an attorney handling a liability case that involves Medicare beneficiaries, or represent a party likely to be Medicare enrolled in the next few years, you should be well-versed in federal law enabling Medicare to recover payments for injury related care if beneficiaries receive settlement proceeds for those injuries from a third party (a/k/a Medicare's "Recovery Claim").

Since the 1980s, Congress has been expanding Medicare's recovery claim rights. Under current law, Medicare must be reimbursed for any past medical care it has funded stemming from its beneficiary's underlying injury.[1] If that does not occur, the government can file suit to recover Medicare's payment amount plus interest and in some cases double damages.[2] Additionally, Medicare has a right to refuse payment for future medical care linked to the underlying injury if those treatment costs should have been – but were not – addressed as part of the judgment or settlement.[3] In this white paper, we provide an overall risk management roadmap for attorneys – both plaintiffs' and defense counsel – on how to comply with federal laws governing Medicare reimbursement, and address the funding for any future Medicare costs within those settlements.[4]

How It All Began

When the Medicare program first began, it served as the principal source of healthcare funding for its beneficiaries, whether the patient had private health insurance or not.[5] As the program's costs steadily climbed,[6] Congress passed a law in 1980 aimed at reducing the amount of Medicare payouts overall, by making Medicare's coverage secondary to other sources. The Medicare Secondary Payer Act (MSP)[7] purported to ensure that if Medicare beneficiaries received coverage from another entity, then Medicare would not bear the burden of those expenses.

The law and its related regulations have particular significance in personal injury litigation, where cases often involve damages for medical care. Attorneys handling cases where Medicare beneficiaries are alleging physical or mental injuries should review Medicare's potential reimbursement rights in each

case, and determine whether another entity besides Medicare is assuming legal responsibility (via the settlement, judgment, or damage award)[8] for a beneficiary's specific medical costs.

Under the MSP, if Medicare pays for treatment for which its beneficiaries later receive compensation, then Medicare has both a subrogation right and an independent right of recovery to recoup those costs. These upfront payments by Medicare are referred to as conditional payments, because they are subject to another party assuming primary coverage of those costs. Consequently, if a third party ultimately provides settlement proceeds related to injuries involving treatment conditionally paid for by Medicare, Medicare's so-called lien must be repaid.[9]

Another federal law ensures that Medicare is notified of any settlements or damage awards, so that the government is aware of potential payments for which it should be reimbursed. Under the Medicare, Medicaid and SCHIP Extension Act of 2007[10] (MMSEA) insurance carriers and self-insured defendants that actually pay a settlement to a Medicare beneficiary must report those payments (and other information) on a quarterly basis to the Secretary of Health and Human Services,[11] so that the government is cognizant of Medicare treatment it funded for which its beneficiaries later received a third-party payment (i.e. the conditional payments). The U.S. government has the right to file suit to recoup these Medicare funds, *only if* parties have not previously arranged to reimburse Medicare for these expenses.

Where Medicare Reimbursement Stands Today

Medicare's recovery right pertains to both past medical expenses paid and future medical expenses Medicare is likely to pay.[12] In order to comply with the MSP's reimbursement requirement, you should evaluate the case to determine whether Medicare has funded any past medical expenses, and if so, how much Medicare has spent, so that you can determine how much Medicare will in turn need to be paid back. Medicare's recoupment of past medical expenses take priority over any potential future medical costs, and those past conditional payments must be addressed as a case nears resolution and settlements are negotiated. Keep in mind that depending on the amount of the settlement, and the extent of a claimant's injury, it is possible that Medicare's lien could exceed the amount of a litigant's overall recovery or settlement. In those circumstances, parties can seek a waiver or a compromise of Medicare's lien for past care.[13]

Future Medical Costs

While reimbursement of Medicare's past medical costs takes priority over the funding of future medical care, the issue of whether any settlement funds exist for future care is a determination that counsel should make in all cases involving Medicare beneficiaries. In the context of future medical care, the key inquiry is whether money is available and should be identified as payments for future care, in an account known as a Medicare Set Aside arrangement or MSA. A MSA, in its simplest form, is an interest bearing checking account containing settlement funds which will be used to pay for future injury-related care Medicare would otherwise cover. Essentially, it operates like a deductible the claimant pays before getting benefits from Medicare again. Once an MSA is established, and its funds are spent down and exhausted appropriately, Medicare may then be billed for a beneficiary's injury-related care.

It is important to note that, as of the publication of this white paper, CMS has not issued any formal regulations for the structure or establishment of MSAs in liability cases – although officials are expected to do so later this year. This white paper reflects current guidance as of the date of its publication.

We do have an idea of what the MSA regulations could look like, given the Advanced Notice of Proposed Rulemaking (ANPRM) CMS issued last year. On June 15, 2012, CMS released an ANPRM which outlined when a claimant would be required to address the MSA issue. The ANPRM contains broad language which indicates MSAs could be appropriate in an increasing number of cases, if the currently proposed wording is fully adopted.

The ANPRM indicates that there are three overall conditions which, if present in a claim, potentially merit the establishment of an MSA. First, future medical care must be addressed as a component of damages – specifically or generally – in the pleadings, release language, judgment, or damage award. Second, the settling party/defendant/third party has accepted responsibility for future medical costs linked to the underlying injury. Third, there are monies available to fund the specific future medical costs which Medicare would otherwise cover. The ANPRM states:

> "**If an individual or Medicare beneficiary obtains a 'settlement' and has received, reasonably anticipates receiving, or should have reasonably anticipated receiving Medicare covered and otherwise reimbursable items and services after the date of 'settlement,' he or she is required to satisfy Medicare's interest with respect to 'future medicals related to his or her 'settlement' using any one of the following options**."[14]

Under the ANPRM's wording, the first question which must be answered is whether future medical costs are pled, released, or reasonably anticipated to be released in a settlement. Next, the individual or Medicare beneficiary must reasonably anticipate receiving Medicare covered items or services post-settlement. If a settlement generally or specifically addresses future medical care in the original pleadings or the release, that demonstrates reasonable anticipation of future care.

In terms of particular wording, a general – or implicit – reference would, for example, be a release to any and all future claims. A specific – or explicit – reference is one in which the settlement award has a particular designation or dollar value identified for future medical expenses. For instance, if, after a hearing on the merits of the case, a judge or jury has earmarked a specific amount as compensation for the claimant's future medical expenses, then the parties can view that amount as an explicit allocation. Whether the reference is implicit or explicit, the bottom line is that if future care is reasonably anticipated via identification in the pleadings or the release language as a component of the items for which the primary payer or its insured accepted responsibility, then you should address whether funds exist to pay for Medicare's future treatment.[15]

This determination is easier in cases where future care is specifically delineated, as the amount and cost of future care has already been set. Most settlements, however, do not contain such precise identifiers. If that's the case for a claim you're handling, you should still evaluate whether the settlement agreement contains an implicit designation of future medical costs.[16] Plaintiff's counsel should determine whether, within that undifferentiated sum of settlement money, there is an amount which could be reasonably viewed as compensation for future medical expenses, as opposed to other types of damages (such as pain and suffering) pled and released.[17] Later in this article, we'll explain step-by-step how this process works.

However, there's an important prerequisite that needs to be addressed first. Before conducting this analysis, the parties should establish whether all conditional payments to Medicare have been satisfied. Any reimbursement obligations to Medicare for a beneficiary's past medical costs must be addressed, before any funds are put toward the beneficiary's future medical care. Federal statutes and court rulings establish that the reimbursement of any conditional payments Medicare made for past treatment takes priority over the allotment of any future medical costs, within a settlement. So if a claimant's Medicare lien obligations for past care exceed the total amount of compensation (whether explicitly provided or implicitly allocatable) for medical care within a settlement, Medicare's conditional payments must be satisfied before any funds are disbursed for future care.[18]

For example, if there is a $10,000 sum of money in the settlement viewed as compensation for medical care, but the claimant owes Medicare $15,000 for the reimbursement of past medical care, then the potential allocation for any future medical costs has effectively been depleted by the outstanding debt to Medicare for past treatment. There are no funds available for future medical care once Medicare's past reimbursement claims are taken into account.

Ultimately, the ANPRM would apply in cases where a settlement award is obtained, and the pleadings or release language identify (either explicitly or implicitly) future medical expenses as a component of the items or services over which the primary payer or its insured accepted responsibility, and in which funds are available for that purpose.

Of course, the ANPRM is currently a proposal, rather than black letter law. Nevertheless, we believe the ANPRM reflects the path CMS is likely to follow. Consequently, attorneys need to be aware of how their clients' liability cases are likely to be impacted once regulations are fully enacted.

Achieving Compliance

Although the process for evaluating future medical claims is complicated, it is important for attorneys to understand. After resolving these issues in thousands of settlements nationwide, we at the Garretson Resolution Group (GRG) recommend using a four step approach to ensure MSP compliance on the future medicals issue:

1. **Screen** to determine if the claimant is a Medicare candidate
2. **Analyze** whether the gross award contains funds available to pay for a claimant's future medical expenses
3. **Value** the claimant's actual future cost of care needs
4. **Educate** the claimant and parties about MSA obligations

This formal approach allows the parties to determine exactly what action is required. Let's look at this process step-by-step:

Step 1:

Screen to determine if the claimant is a Medicare candidate

First, you must determine if the claimant is a candidate for Medicare coverage. So you'll need to review the facts of your case to determine or verify the claimant's Medicare enrollment status. If a plaintiff is currently a Medicare beneficiary, you'll need to ensure past Medicare conditional payments have been satisfied, and evaluate the future medical costs issue and the potential need for an MSA. Additionally, if your client is likely to become entitled to Medicare coverage within 30 months of the resolution of the case, that indicates eligibility for Medicare and the same need for MSP compliance.[19] To that end, if a claimant is 62 ½ or older, has permanent kidney failure requiring dialysis or a transplant, has ALS or Lou Gehrig's disease, or has applied for Social Security Disability Insurance, you should likewise evaluate the propriety of an MSA because these circumstances also trigger Medicare eligibility.[20]

In fact, if the claimant meets at least one of the factors listed above for Medicare eligibility, you should proceed with the MSA analysis. But, if your client does not meet any of these criteria for Medicare coverage, an MSA is likely not appropriate. If a claimant has no basis for Medicare eligibility, you should retain records in your file which reflect the question-and-answer/verification process with your client, to establish the steps taken to assess and protect Medicare's interests.

To continue with the MSA analysis, the next step is to determine if Medicare could be liable for the claimant's future medical costs. Counsel for the parties, along with the treating physicians, will need to evaluate the claimant's injury, and the need for future treatment linked to the underlying injury. If it is determined that, because of the injury at issue, a claimant will need future medical treatment funded by Medicare, then the claimant could be considered a potential candidate for an MSA. If this is the case, then you should move to the next stage of the evaluation.

However, if you determine the claimant is **not** a potential candidate for an MSA, then you should document the basis for that conclusion in your file. We recommend that you retain records which demonstrate what materials you reviewed to ensure that Medicare's interests were adequately protected and, in light of that review, how you established that an MSA was not needed. These records often include reports from treating physicians, and other factual evidence. That way, you will have sufficient support if CMS later requests a review of your MSA decision.

Step 2:

Analyze whether the gross award contains funds available to pay for a claimant's future medical expenses

If the claimant *is* a candidate for Medicare enrollment, the parties must next determine if the (potential) gross settlement proceeds contain sufficient dollars available to fund any MSA obligation. To do this, parties should assess the claimant's full measure of damages sustained[21] and compare those to the

(potential) gross award. The parties should then use that comparison to conclude whether: i) the (potential) gross award actually contains dollars available for future medicals;[22] or ii) whether the claimant is not being compensated for future medicals[23] although future medicals are a damage component being pled and released or there is evidence that the claimant may need future injury-related care.[24]

Again, this review should only occur if the claimant has been determined to be a candidate for Medicare as outlined above, and there is an undifferentiated lump sum damage award. This analysis will help the parties evaluate whether the settlement implicitly contains funds reasonably intended to compensate for future medical costs which Medicare would otherwise cover. This calculation of available funds should include an evaluation of how much, if any, of the settlement proceeds are needed to pay past medical expenses and out-of-pocket future medical costs, including co-payments, special medical equipment, and any non-medical expenses that are reasonably anticipated as a result of the underlying injury (for example, home modifications or special needs items). Keep in mind that, under the facts of the case, the proceeds may not contain funds for future medical care even though the release may state it pertains to “all claims past and future,” or contains language to that effect.

The initial step in this analysis is to conduct a damages evaluation which determines the total potential damages in the case, in comparison to the net amount of funds actually being awarded in the settlement. In calculating this figure for total compensable damages, the parties should evaluate each type of particular damage identified in the pleadings – for instance, loss of earning capacity, pain and suffering, etc., and also take into account any jurisdictional limits or caps limiting the maximum amount of damages which can be awarded for certain types of injuries, and then make a reasonable good-faith estimation of the total value of each category of damages identified in the pleadings. This total value can be determined by using figures identified in the pleadings and/or using relevant jury verdicts in cases with similar facts.

Once the total compensable damages have been established, then that number needs to be compared to the amount of total damages being recovered, so the percentage of total or gross recovery can be calculated. This gross recovery value is critical. If this figure shows that a claimant is recovering all or nearly all of the damages pled, then the parties’ attorneys can use a reasonableness standard to determine whether a portion of the gross recovery is definitive compensation for future injury-related care. On the other hand, if there’s a significant difference between the total potential damages and the recovered damages, then the gross recovery percentage can be used to help the attorneys evaluate whether there is an implicit allocation for future medical costs within a settlement.[25]

If, after completing this damage allocation analysis a reasonable person would conclude that the gross award **does not** contain an implicit identification of the payment of future medical costs, then an MSA would likely not be needed.[26] By conducting this analysis and reaching this conclusion the settling parties have taken steps to consider and account for Medicare’s interests, and thus, have met their obligations under the MSP.[27] Before closing their files, the parties should retain their records of the future medical costs analysis.

However, if a reasonable person would likely conclude that part of the settlement can be implicitly allocated for future medical costs – despite a lack of concrete wording to that effect in the settlement agreement – then the MSA evaluation should continue. The next step is for the parties' attorneys to assess how that future care is to be funded, and whether the burden will be on Medicare or another insurance carrier or entity to pay for it. If Medicare is to be the primary payer for that future healthcare, then an MSA may well be appropriate. Subsequently, the parties' attorneys need to determine the appropriate amount for the MSA by calculating the dollars available to fund future care, plus the type and amount of future injury-related care for which Medicare would otherwise be responsible. We will walk you through this process in Step 3.

Step 3:

Value the claimant's actual future cost of care needs

The valuation phase involves identifying the amount of funds needed for the MSA. We recommend using a future cost of care analysis to calculate the appropriate funding level. It's critical to properly fund an MSA in order to protect a claimant's future Medicare benefits, because Medicare could withhold future coverage if officials determine the program's interests were not adequately addressed in the MSA. As such, we believe the best way to ensure the proper funding amount is to identify all future injury-related care services/expenses the claimant is reasonably expected to incur. Once those future costs of care are tallied, the sum for those services/expenses should be apportioned between Medicare- and non-Medicare covered services/expenses. Next, counsel should compare the total amount of dollars available within the settlement to fund future medical costs (Step 2) to the total amount of injury-related and Medicare-covered services from the future cost of care analysis (Step 3). Whichever amount is lower is the appropriate amount for the MSA.

Step 4:

Educate the claimant and parties about MSA obligations

At this point you've established that an MSA is appropriate and calculated the amount needed for the MSA. The next step is determining how to administer and finance the MSA. MSA administrators determine the timing and amount of payments from the account. Although all MSA accounts must be insured, MSAs in liability cases may be either self-administered or administered by a professional custodian, such as Affiance Partners. In terms of financing, liability MSAs may be funded either with a full lump sum dollar amount upfront or with a structured plan involving periodic payments, such as an annuity.

Now that you know the importance of accounting for Medicare's interest in future medical costs, and you've learned the in-depth process needed to evaluate the propriety of an MSA in relevant cases, you may be thinking that it's too much to handle on your own. Well, GRG has developed a tool that can ease your MSP compliance burden.

MSA Decision Engine: The Lowest Cost of MSA Compliance

To allow parties to apply a consistent and cost-effective procedure for determining the propriety of MSAs, GRG developed the MSA Decision Engine. It's a patented tool available on our website, 24 hours a day/365 days a year – built on a foundation of all current guidance on the funding of future medical expenses. The Decision Engine aims to help attorneys ensure MSP compliance for the funding of future medical expenses via GRG's specific damage allocation formula, which we developed using our expertise as the pioneers of the lien resolution industry.

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The MSA Decision Engine can be accessed anytime on a "self-serve" basis. After logging onto a secured web platform, users answer a few simple questions. The users' responses result in one of two initial answers: 1) the user is taken to a page – available for free download or printing – advising that an MSA is not necessary; or 2) the user sees a pop up screen stating that an MSA might be appropriate, but more information is needed to make that determination. If more information is needed, users are then asked a series of questions regarding the claimant, his/her injury, his/her healthcare history, and the litigation itself. Based on the responses to those additional questions, the Decision Engine provides further guidance concerning the future cost of care issue. Attorneys may then download the Decision Engine's results in a PDF document which contains the users' data, sample settlement/release language, and an MSA Disclosure Form for the claimant to review and sign. Attorneys can then use the Decision Engine's results to help establish that they have fulfilled their compliance obligations as they have a report showing how they evaluated, considered, and sought to adequately protect Medicare's future interests.

So is it Ethical to Outsource MSA Analysis?

Ethics opinions from the American Bar Association (ABA) and other legal groups indicate that outsourcing work to non-lawyers – such as GRG – is permitted provided certain conditions are met. In 2008, the ABA issued a formal opinion which outlined the ways attorneys can outsource with integrity. The opinion noted that outsourcing is sanctioned as long as the outsourcing lawyer a) delegates tasks to individuals who are qualified to perform them, and b) confirms that those tasks are properly completed. The outsourcing lawyer remains directly accountable for the services rendered to his/her client, and the competency of the work performed on his/her client's behalf.

Then in 2012, the ABA's Ethics Commission approved Comments to the Model Rules of Professional Conduct regarding outsourcing, which noted that "lawyers increasingly need to go outside their own firm to ensure" their clients receive competent and efficient service.[28] The new Comments basically reiterate that lawyers who outsource need to make "reasonable efforts" to ensure the outsourced work contributes to the overall representation of their clients. If non-lawyers are utilized, the outsourcing lawyer needs to ensure the services are provided in a compatible manner with the lawyer's obligations, including that of confidentiality.

The question of whether to seek help on the MSA issue becomes a simple business decision: do I build an MSA solution internally or do I buy an MSA solution from someone experienced in this area?

If you decide to partner with an outside group to handle MSAs (and lien resolution), first ask the group to provide all the information needed for due diligence. For example, does this company offer deep subject matter expertise? Can it demonstrate fully-developed work flow and lien audit models? Has its work product and methodology been vetted by third party neutrals (such as a U.S. federal court)?[29] Also, make sure you understand when and how that outside group's fees could be passed through as a case expense to your client.

Conclusion

Navigating the MSA issue is a complicated, but critical component of settlement resolution in today's litigation realm. By determining if an MSA is appropriate under your case-specific facts and documenting your file with the result of that analysis, you will have met your compliance obligations under the MSP. If analyzing the future cost of care issue is not part of your standard protocol for resolving personal injury claims, it's time to address this issue and potentially update your case intake procedures so as to capture needed data.

For more information, please visit our website: www.garretsongroup.com, or contact John Cattie at 704-559-4300 or jcattie@garretsongroup.com.

About the Authors

John heads the Future Cost of Care practice at Garretson Resolution Group. In his role, John counsels attorneys nationwide with respect to Medicare compliance under the Medicare Secondary Payer Act. In particular, he advises attorneys on the applicability and use of Medicare Set-Aside Arrangements (MSAs) as a part of workers' compensation, liability and no-fault settlements.

John received his BA in International Studies from the University of North Carolina at Chapel Hill in 1997, and his JD/MBA from Villanova University in 2003. Licensed to practice law in North Carolina and South Carolina, John is a member of the Mecklenburg County Bar, the North Carolina Bar Association, the South Carolina Bar Association and the American Bar Association. Serving as a neutral third party with respect to Medicare compliance, John is a member of DRI, WILG, AAJ and NAMSAP. Within DRI, John serves as the Vice Chairman of the DRI Medicare Secondary Payer Task Force and on the Young Lawyers Steering Committee as Corporate Counsel Co-Vice Chairman. He is a frequent speaker at continuing education events nationwide on the subject of Medicare Secondary Payer compliance.

As the Publications Manager at the Garretson Resolution Group, Katie Hosty oversees the content of GRG's work in various outlets including educational seminars, national and state legal publications, websites, and social media. Prior to joining GRG, Katie worked as both a defense attorney and a journalist. She spent nearly seven years as a litigation associate in large Chicago law firms, where she successfully defended a wide breadth of commercial cases and tort claims in state and federal court. Katie is licensed to practice law in Indiana and Illinois, having earned her law degree at the University of Notre Dame.

Prior to attending law school, Katie worked in Washington, D.C., as a writer for The Associated Press and a Writer/ Producer for Fox News Channel's "Special Report with Brit Hume." She is a graduate of Ohio University's E.W. Scripps School of Journalism.

[1]42 U.S.C. § 1395y(b)(2)(B)(ii)(Medicare is entitled to reimbursement "if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service.")
[2] If suit is filed to collect reimbursement, then the U.S. government can recover twice the amount of the cost of Medicare's payment, plus interest, against the entity which made payment to the Medicare beneficiary. 42 C.F.R. § 411.24(c)(1)-(2); see also 42 C.F.R. § 411.24(m). Interest can also be recovered against beneficiaries who receive a payment for which Medicare should have been, but was not, reimbursed. 42 C.F.R. § 411. 24(m).
[3] 42 USC § 1395y(b)(2)(A)ii.
[4] This white paper provides an overview of the compliance process. For a more detailed explanation, please consult GRG's Learning & Resource Center by clicking here.
[5] Peter A. Corning, The Evolution of Medicare from Idea to Law, Social Security, http://www.ssa.gov/history/corning.html.
[6] Medicare beneficiaries were first able to sign up for coverage on July 1, 1966, although Medicare was passed into law on July 30, 1965. http://www.ssa.gov/history/hfaq.html (Q2).
[7] 42 U.S.C. § 1395y(b)(2).
[8] For ease of reading, the authors will use the word "settlement" to collectively refer to a settlement, judgment, or damage award throughout this paper, although Medicare's right to reimbursement under the MSP pertains to settlements, judgments, and damage awards – not just settlement proceeds.
[9] For convenience purposes, the authors refer to Medicare's right to be repaid for conditional payments made as "liens," despite the fact that Medicare's recovery rights are more expansive than lien rights under 42 U.S.C. § 1395y(b)(2) and (b)(3).

[10] Medicare, Medicaid and SCHIP Extension Act of 2007, Pub. L. No. 110-173, 121 Stat. 2492, codified at 42 U.S.C. § 1395y(b)(8).
[11] Section 111 of the MMSEA also addresses new amendments to the Medicare Secondary Payer statute regarding reporting requirements for Group Health Plans. This article, however, only addresses the amendments related to providers of liability insurance (including self-insurance), no fault insurance and workers' compensation insurance.
[12] Technically, as opposed to a right of reimbursement for future injury-related medicals, the MSP Act endows CMS with the implicit right to NOT make payments for an injured person's future injury-related care when another primary plan or payer has already accepted responsibility for such payments and has made payment to an injured person of such funds to be used for the injured person's future cost of care needs. It is this right NOT to make a future payment which distinguishes this right from rights to reimbursement for any conditional payments made under the reimbursement provisions of the MSP Act.
[13] After a settlement, judgment or award, Medicare may grant a full or partial waiver of its recovery amount with respect to the beneficiary. There are two options for Waiver: §1870 (c) Waiver and §1862 (b) Waiver. Criteria for such waivers generally include: 1) the beneficiary being without fault and the recovery, 2) effecting financial hardship or being against equity and good conscience. Prior to a settlement, judgment or award, Medicare also may enter into pre-settlement discussions regarding a compromise of Medicare's reimbursement claim.
[14]See Advance Notice of Prop. Rulemaking, Fed. Reg., pages 35917-35921 (June 15, 2012); https://www.federalregister.gov/articles/2012/06/15 (last visited September 12, 2013). http://www.regulations.gov/#!documentDetail;D=CMS-2012-0073-0001 (last visited September 16, 2013).
[15] A recent federal court case demonstrates the continuity of this rationale. In *Weinstein v. Sebelius*, 2013 U.S. Dist. LEXIS 41594 (decided February 13, 2013), the court provides three MSP takeaways: 1) CMS has a right of recovery when a beneficiary seeks medicals as damages and the parties resolve the claim; 2) broad and general pleadings by the claimant lead directly to CMS possessing broad rights of recovery; and 3) use of a court-approved allocation based on the merits (or other reliable allocation methodology) is an effective way to determine that portion of proceeds available for medicals versus non-medicals.
[16] *See Early v. Carnival Corporation*, No. 12-20478-CIV-Goodman (S.D. Fla. February 7, 2013); *see also Guidry, et al. v. Chevron USA, Inc.*, Civ. No. 6:10-cv-00868, 2011 U.S. Dist. LEXIS 148942 (W.D. La. December 28, 2011); *Sterrett v. Klebart*, 2013 Conn.Super. LEXIS 245 (filed February 5, 2013)(unreported).
[17] While the undifferentiated sum of money may be intended to be consideration for the release of the defendant's liability for future medical expenses, the challenge is determining whether or not some portion of the undifferentiated sum can be reasonably identified as comprising future medical expenses as opposed to the myriad other damage components pled and released.
[18] Starting with 42 C.F.R. §411.20 the regulations CMS enacted in support of the MSP carefully and consistently provide CMS with a priority right of reimbursement for conditional payments made. However, when a claimant's conditional payment/lien

obligations exceed amounts allocated to all medical expenses in an award, those conditional payments are to be addressed before obligations for future costs of care. If the obligations for past care cannot be fully satisfied by the settlement, then there are essentially no funds available to address future costs of care. For example, if part of the settlement is intended to address future healthcare costs, but the amount for future care is less than the amount of money owed to Medicare for past costs, those "future" funds would be effectively spent on past medical expense reimbursement obligations.

[19] 42 U.S.C . § 1395(c).

[20] *Id.*

[21] Stated another way, defense entities (*i.e.*, defendants, insurance carriers, etc.) should assess what the potential exposure is on the particular claim.

[22] *Benoit v. Neustrom, et al.,* 2013 U.S. Dist. LEXIS 55971 (April 17, 2013), where the liability MSA obligation was fully satisfied for less than the full value of the claimant's future injury-related care expenses otherwise covered by Medicare.

[23] *Sterrett et al. v. Klebart et al.,* 2013 Conn. Supp. LEXIS 245 *4-5 (February 5, 2013), where the Court concluded that no liability MSA was needed based on the parties' efforts to identify that the gross award was not paid in order to compensate the claimant for future medicals.

[24] *See Zinman v. Shalala*, 67 F.3d 841, 846 (9th Cir. 1995), where the Court foresaw this inherent problem in liability settlements under the MSP Act. *See also Benson v. Sebelius*, 2011 U.S. Dist. LEXIS 30438 (March 24, 2011) ("…if a settlement covers both medical and nonmedical costs, CMS's reimbursement may be apportioned so as to reach only the portion of the settlement allocated to cover medical costs.")

[25] This evaluation will determine whether part of the undifferentiated lump sum settlement is reasonably intended to compensate a claimant for potential future medical expenses as opposed to other damage components that have been pled and released, past medical costs, and anticipated out-of-pocket costs related to the underlying injury.

[26] *Sterrett* at *4-5.

[27] Again, this white paper provides an overview of the MSP, and attorneys' obligations therein, as of the date of its publication, September 27, 2013.

[28] "Ethics 20/20 Rule Changes Approved By ABA Delegates With Little Opposition" 28 Law. Man. Prof. Conduct 509 (August 15, 2012).

[29] *Smith v. Marine Terminals of Arkansas*, 2011 U.S. Dist. LEXIS 90428 (August 9, 2011).